Application of the

COMMONWEALTH OF MASSACHUSETTS

to the

Health Resources and Services Administration's

STATE PLANNING GRANT PROGRAM

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Submitted by

The Commonwealth of Massachusetts
Division of Medical Assistance

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PROJECT ABSTRACT

Current Status of Access to Insurance: The Commonwealth of Massachusetts has been and continues to be a leader in expanding access to health insurance for all its residents. In sharp contrast to national trends, the rate of uninsurance in Massachusetts for all ages has fallen from 12.6% in 1997 to 10.3% in 1998 (CPS). In those same years there has been a concomitant increase, by more than 200,000, in the number of people who receive assistance from MassHealth, the state's comprehensive health insurance program for low-income residents, elders, and people with disabilities.

Under current insurance laws, health insurance is available to all residents of Massachusetts. This includes people 65 years of age and older who do not qualify for Medicare. Moreover, Massachusetts has several public programs to assist those with very low incomes and those who meet certain other criteria. Nevertheless, many Massachusetts residents still lack health insurance coverage.

Earlier Efforts to Expand Access: The Commonwealth has a long history of commitment to expanding access to health insurance among all its residents. In 1988, the Legislature enacted and the Governor signed into law the Health Security Act, a universal health care law that would have resulted in coverage for all Massachusetts residents. Unfortunately, subsequent fiscal and economic difficulties delayed implementation of the law and eventually led to its repeal.

However, the commitment to finding affordable ways to expand access to insurance did not wane. In 1992 and again in 1996, the Legislature enacted several changes to laws regarding the individual and small group health insurance markets. In essence, these changes made health insurance available to all residents regardless of employment or health status. Changes to our public programs have also had a significant impact on the availability of health insurance. To expand access for low-income residents, in 1994 the Commonwealth requested, and subsequently received, an "1115 Research and Demonstration Waiver" that allowed us to provide Medicaid-like coverage for people with higher incomes and categorically ineligible for Medicaid. The Waiver Demonstration Project, also called MassHealth, includes premium assistance for working adults, as well as incentives to employers to provide and contribute to the cost of insurance for low-income workers. Legislative authority to implement the Demonstration Project was received in 1996.

The Demonstration Project, implemented in stages during 1997 and 1998, has allowed the Commonwealth to take full advantage of the Children's Health Insurance Program and to assist more children than we could have assisted had we not received the Waiver. Through innovative partnerships with advocacy groups, schools, community-based organizations and provider groups, the Commonwealth has become a national leader in the enrollment of children into its CHIP and Medicaid programs.

Despite the success that Massachusetts has had in reducing the rate of uninsurance, there is widespread agreement that we should do more. The Governor, Speaker of the House and the Senate President convened a Task Force in June of 2000 to evaluate the status of health care in Massachusetts, including access to both health care and health insurance, during the next 18 months.

Proposed Project: As stated earlier, in a technical sense Massachusetts already has "universal access" to health insurance, in that no one who wants to buy insurance may be denied. However, clearly some obstacles remain that have prevented many residents from obtaining health insurance. We believe that

a principal obstacle is the high cost of coverage. Therefore, the issue that Massachusetts will address under the State Planning Grant is *affordability.*

The goals of the project are as follows:
1. Define "affordable" for residents based on income and family status.
2. Determine the most appropriate level of insurance coverage (benefits and deductibles) to serve as a "benchmark" based on the most prevalent insurance products in various categories of subscribers.
3. Identify existing barriers to that benchmark level of insurance coverage (e.g. affordability; awareness; risk-taking behavior; competing priorities).
4. Develop proposals for achieving universal access to affordable insurance that support and enhance the private insurance market while ensuring that the safety net of public programs is available for those who need it.

Data collection activities and related analyses will be performed to determine the following:
1. The socio-economic characteristics that are most determinative of insurance coverage.
2. The levels of expenditures for health insurance and health care services that are acceptable for subscribers (at various income levels) and employers.
3. The degree to which insurance products that are currently available would cover services presently reimbursed by the Uncompensated Care Pool or that are self-paid by patients.
4. The prevalence of available insurance products in predefined categories of subscribers (e.g. based on income, family status, employment, etc.).
5. The attractiveness of various products to predefined categories of potential (currently uninsured) subscribers and employers.

Lead Agency and Collaborators: The Division of Medical Assistance (DMA) will be the lead agency for this project. DMA administers the MassHealth program, and was responsible for developing and implementing the 1115 Waiver. The Core Project Team will be comprised of DMA, the Division of Health Care Finance and Policy (DHCFP), the Department of Public Health (DPH), and the Division of Insurance (DOI). Other participants will include the state's Executive Office of Elder Affairs, the Department of Mental Health, Department of Employment and Training, the Department of Revenue, the Group Insurance Commission, representatives of the Massachusetts State Senate and House of Representatives, and the University of Massachusetts. Participants from the private sector will include Health Care For All, Associated Industries of Massachusetts, the Massachusetts Medical Society, the Massachusetts Hospital Association, League of Community Health Centers, Massachusetts Association of Chamber of Commerce Executives, Massachusetts Business Association, the Massachusetts Health Care Purchaser Group, and representatives of Massachusetts insurance companies.

Projected Results: The Team expects that at the conclusion of this project we will have developed a set of coverage options that are feasible and affordable for subscribers, employers, providers, insurance companies, and the taxpayers. The Team will consider and evaluate any reasonable approaches and combinations of approaches to achieving this goal, including, but not limited to, the following:
1. Closing existing gaps in MassHealth eligibility for those who are low income but who do not meet certain categorical requirements.
2. Expanding eligibility for existing public programs.
3. Ensuring the availability of affordable insurance products.
4. Providing some form of financial assistance for those below a defined income level who purchase a group or individual insurance product.
5. Expanding current subsidy programs for residents with employer-based insurance.

CURRENT STATUS OF HEALTH INSURANCE COVERAGE

Introduction

Massachusetts' health care financing and delivery system is distinguished by several characteristics. It has a high rate of employer-based coverage (66%) and an overall low rate of uninsurance. This low rate of uninsurance reflects, in part, the state's expansion of the Medicaid program, MassHealth, to include additional low-income populations previously ineligible. Despite high rates of coverage and broadened safety net programs, a segment of the Massachusetts' population remains uninsured.

Summary of Trends

Massachusetts' uninsured rates for all ages has dropped from 12.6% in 1997 to 10.3% in 1998 (CPS). In comparison, the United States' uninsured rate climbed during this same time period from 16.1% to 16.3%. In fact, Massachusetts is one of just a few states that actually saw its rates of uninsurance decline during this period. Much of this decline has been attributed to the significant expansion in public insurance programs.

While the CPS data is nationally representative, it does not adequately depict the true uninsurance rate for Massachusetts, specifically. According to preliminary results from a state-sponsored, household survey being conducted in Massachusetts currently, the overall uninsured rate in Massachusetts for all ages is 5.8%. In 1998, the same state commissioned survey found an uninsurance rate of 8.1% for all age groups. Massachusetts, through its strong economy and efforts to expand coverage to low income citizens, has made terrific strides in the past several years at lowering its' uninsurance rate.

Survey results from the state's 1998 survey indicated that younger adults are more likely to be uninsured than children 18 years of age and younger and adults ages 40 and older. Low-income residents and minorities are also more likely to be without insurance and males have a greater likelihood of being uninsured than females. Furthermore, while people without health insurance are likely to be employed and working similar hours as insured people, they are more likely to have multiple jobs and work at small firms with 50 or fewer employees.

While we believe the primary reason that people remain uninsured is cost, our understanding is not very sophisticated. For example, we do not understand the complexities of consumer preferences - particularly for those who could afford to purchase insurance - and how these preferences predict their willingness-to-pay. Nor do we have a good understanding of some of other barriers that may exist, including access to information and ability to comprehend the proliferation of insurance options.

The results of the activities proposed in this application will contribute to our understanding of these barriers, as well as, the complex relationship among employer-based, individual, and publicly-funded insurance systems.

Demographics

A summary of demographic characteristics of the Massachusetts uninsured population from the 1998 state sponsored survey follows:

Rate of Uninsured by Age

Children and older Massachusetts' residents are more likely to have insurance than younger, working age adults. While only 4.4% of children ages 0 to 5 and 7.1% of children between the ages of 6 and 18 were uninsured, nearly 13.7% of adults 19 to 39 years of age were uninsured. Similarly, 7.1% of adults ages 40 to 64 were uninsured while virtually all adults 65 and over are insured.

Rate of Uninsured by Income

Trends in the rate of uninsured suggest that as income increases the rate of uninsurance decreases. About 20% of individuals with incomes below 133% of the federal poverty level (FPL) and 23.2% of those with incomes between 133% and 149% of the FPL were uninsured. 15.4% of individuals reporting income between 150 and 184% of the FPL, 7.6% of individuals with incomes between 185 and 199% of the FPL and less than 3% of those with incomes greater than 400% of the FPL were uninsured.

Rate of Uninsured by Race and Gender

White individuals are more likely to be insured than non-whites in Massachusetts. Approximately 17.8% of Hispanics and 14.5% of African Americans are uninsured compared to 6.2% of whites. Males (9%) are also more likely to be uninsured than females (6%).

Rate of Uninsured by Employment Status

The 1998 state sponsored survey showed that although both uninsured (67.4%) and insured (91.5%) residents are likely to be employed, a greater proportion of uninsured residents (30%) are self-employed or self-employed with an additional job compared to insured workers (8%).

Among the working uninsured, 28.6% reported they were eligible to receive health insurance coverage through work. The primary reasons cited for not participating in the employer-based plan were unaffordable out of pocket costs (62.7%), or required waiting period before receiving health care benefits (25.9%).

MassHealth (Medicaid) Expansion Program

A significant proportion of the low-income population is enrolled in the Medicaid program-principally because its income eligibility standards are quite generous and because it has adopted most federal optional eligibility categories. For example, the Massachusetts' Medicaid program (MassHealth) provides coverage to 64% of residents with incomes below 150% of the FPL versus only 51% for the United States overall. The coverage expansion initiative under a Section 1115 Medicaid Research and Demonstration Waiver, called MassHealth, is among the most ambitious state initiatives across the country. The demonstration is comprised of six interrelated components designed to improve access to health insurance and to stimulate the private offering of affordable coverage. The primary target groups, representing approximately 80% of the uninsured population below 200% of the FPL, are: working poor (37%); low-income children, families and disabled (26%); and low-income long-term unemployed (16%). Additional uninsured populations targeted are the low-income short-term unemployed, working disabled adults and children, and populations limited by private insurance barriers, such as, pre-existing condition exclusions and waiting periods.

MassHealth has also expanded coverage of pregnant women and infants at or below 185% of the FPL to cover all children through the age of 18 who are at or below 200% of the FPL and established

a New State Benefit Plan (called MassHealth Basic) that extended coverage to long-term unemployed individuals and other adults whose gross incomes are no greater than 133% of the FPL.

Established under the waiver as part of MassHealth, the Insurance Partnership was designed to assist employers and employees of small firms (less than 50 employees) with the cost of insurance premiums. The Insurance Partnership provides subsidies to workers with incomes below 200 percent of the FPL for private insurance coverage. It also provides subsidies to small firms that contribute at least 50 percent of premium costs for plans that meet state standards. Because 33% of the working uninsured work in firms with more than 50 employees, they are ineligible. Thus, the challenge of providing access to affordable coverage for this subset of individuals remains.

These policy expansions have resulted in a 39% increase in MassHealth enrollment of non-institutional members, under 65 years of age, from 557,372 (July 1997) to 776,7468 (June 1999). This increase includes 394,314 children (+29%) and 382,154 adults (+52%).

Access to Health Insurance in the Private Market

In 1991 and 1996, the state legislature enacted a series of insurance market reforms. These reforms, restricting insurers' ability to exclude high risk/cost individuals from insurance coverage, make private insurance available to virtually all Massachusetts residents. Previously, individuals who were unable to obtain private coverage due to pre-existing health conditions had sought coverage from MassHealth. These individuals may now be eligible for private coverage and, for some, DMA has an opportunity to provide them with premium assistance rather than full coverage. However, by prohibiting insurers from medically underwriting, the insurance market reforms may cause premiums in the small group and non-group markets in particular to increase, limiting the affordability of coverage and forcing some who are currently covered to drop coverage that has become unaffordable. If this occurs, instead of reducing the burden on public programs, these reforms may increase demand for public coverage or subsidy. There is a wide range in the non-group insurance rates approved for 1998.

The Uncompensated Care Pool

Massachusetts also established an Uncompensated Care Pool to distribute the burden of free care and reduce the incentives to under-serve residents who are uninsured. The Uncompensated Care Pool subsidizes hospitals and community health centers that provide disproportionate amounts of uncompensated care, relying on direct assessments on hospitals, as well as mandated direct contributions from all third-party payers for funding.

Massachusetts' Current Delivery System

Massachusetts has one of the highest managed care penetration rates in the nation. Excluding managed care Medicaid and Medicare members, the Commonwealth's managed care penetration rate in 1998 was 43%. Eighty-one percent of the State's managed care membership market is comprised of three licensed HMOs. The managed care penetration rates for the Medicaid and Medicare populations are also much higher for Massachusetts than the nation. In 1998, Massachusetts' managed care penetration rate for the Medicaid population was 70.6% compared with 54.1% for the nation and the state's 1999 Medicare managed care penetration rate was 23.7% compared with 16.5% for the nation.

Recent consolidations, mergers and acquisitions in the health insurance and HMO industry, particularly in Massachusetts, threaten to stifle competition and limit the ability of even large health care purchasers to negotiate discounted rates. Massachusetts' managed care market is currently dominated by three HMOs, and it is likely that there will be further concentration in the market as these organizations merge or acquire some of the smaller niche market HMOs. The market power and negotiating strength of the three dominant HMOs may be reflected currently in their substantially lower rates for the new nongroup insurance products.

In the previous year, hospitals, provider networks, and managed care organizations have experienced financial difficulties. It is anticipated that health insurance premiums will increase significantly. Thus, rates must be closely monitored to register changes and ensure regulatory intervention if necessary to avert collapse of the private insurance market. While these changes are sure to impact the health insurance market, the full effect is not yet known.

Access to Primary Care

Massachusetts has a strong network of programs and providers that deliver primary care services to low-income individuals. These programs provide funding for community health centers (CHCs), the Children's Medical Security Plan, CenterCare, the Medical Security Plan and the Senior Pharmacy Plan. CHCs provide primary care and education to low-income populations, targeting such health issues as AIDS, substance abuse, pre-natal care, child immunizations and family well-being. In addition, Massachusetts funds two innovative programs, Boston HealthNet and Cambridge Network Health, that provides comprehensive outpatient and inpatient coverage for the uninsured. One objective of these initiatives is to encourage use of preventative and primary care to deter inappropriate use of costly emergency care.

These programs have proven themselves to be effective as evidenced by the decrease in the rate of preventable hospitalizations and improvements in health status indicators for the state population. For example, the rate of preventable hospitalizations in the Commonwealth has declined an average 7.3% annually between 1992 and 1996 (measured as a percentage of the overall population as well as a share of total hospital discharges). Making inferences from aggregated trend analyses must be done with caution. Still, the relative decline in preventable hospitalizations suggests that people with ambulatory care sensitive conditions are today more likely to receive treatment before their conditions advance to the point where they require inpatient services. Massachusetts also scores well on standard measures of health, often higher than the national average. The State's infant mortality, low birth-weight, and premature death rates are favorably lower than the overall national rates.

Through MassHealth, the Uncompensated Care Pool, Community Health Centers and other public health programs, the state has demonstrated its capacity, as well as its commitment to supporting comprehensive and quality care for low-income residents.

EARLIER EFFORTS TO REDUCE THE NUMBER OF UNINSURED RESIDENTS

Introduction

The Commonwealth of Massachusetts has an extensive history of health care reform centered on providing access to and financing of health care. Through reforms of the private insurance markets and an expansion of public programs that assist those in need, Massachusetts has reduced the number and the percentage of uninsured residents in the state, in sharp contrast to national trends. The rate of uninsurance in Massachusetts for all ages has fallen from 12.6% in 1997 to 10.3% in 1998 (CPS). In those same years there has been a concomitant increase, by more than 200,000, in the number of people who receive assistance from MassHealth,

Historically, Massachusetts has provided very generous benefits under public health care programs, primarily (though not exclusively) Medicaid. Efforts to address the issue of the uninsured who have historically been ineligible for public programs – most notably working individuals and families - have been less successful. However, recent events indicate that there is strong public support for expanding access to coverage even further.

Universal Coverage

In the late 1980s and early 1990s, rising health care costs and the increasing number of uninsured alarmed states sufficiently to warrant state initiatives to expand access to health care and contain health care costs. In 1988, the Massachusetts legislature enacted the Health Security Act, a universal health care law that would have resulted in coverage for all Massachusetts residents. Dubbed "Play or Pay," this law required employers to provide health insurance to workers beginning in 1992, or to pay a special per-worker tax that the state would use to provide coverage to those not covered by employer-based insurance. Other states considered this approach, but strong opposition to employer mandates doomed these attempts across the country. That Massachusetts was able to enact such a law when similar efforts in other states were unsuccessful is evidence of strong public support for universal coverage.

However, in the years between enactment and scheduled implementation Massachusetts was hit with massive budget shortfalls and an economic recession. In response, the Legislature delayed implementation of the Health Security Act in 1991 again in 1994 and 1995. Finally, as part of law that implemented sweeping changes in the Medicaid program and other provisions regarding health care, the law was repealed.

Although bills to create a universal "single payer" system have been filed nearly every year since 1986, these bills have never secured widespread support. Despite these odds, there is clearly overwhelming support for other mechanisms to expand access to insurance.

Comprehensive Health Care Reform

In 1994, the Division of Medical Assistance applied to the federal Health Care Financing Administration (HCFA) for a wavier of Section 1115 of Title XIX of the Social Security Act, the act that governs the Medicaid program. The application requested authority to implement a 5-year research and demonstration project to expand health insurance to certain populations not covered by Medicaid.

In this "1115 Waiver" application, the Division requested authority to do the following:

- Establish a new umbrella term, MassHealth, to describe programs providing health insurance to eligible populations. The old "Medicaid" program would be subsumed under the more expansive MassHealth program.
- Increase in income standards for Medicaid members to from 100% FPL to 133% FPL (standard remained at the higher 185% FPL for pregnant women and infants)
- Create the Insurance Reimbursement Program (IRP), which was to consist of an employer subsidy and employee subsidy for employees at or below 200% FPL
- Eliminate the asset test for eligibility, and switch from net to gross income as the basis for eligibility determination.

The Division gained approval of the Demonstration with the broad policy objective of increasing health insurance coverage while curbing the growth of the Commonwealth's disproportionate share hospital (DSH) and uncompensated care pool expenses. The Commonwealth finances its' expanded health insurance coverage for the state's neediest citizens by redirecting state-only expenditures and uncompensated care pool funds; by utilizing revenues from increased cigarette taxes; and by placing greater reliance on managed care. Rather than funding health care for those with acute needs through safety net providers, the MassHealth demonstration proposed to provide access for the uninsured below a certain income level through managed care delivery systems. The rationale was that better access and emphasis on comprehensive, continuous and preventive care would improve quality of care and reduce the need for costly emergency and hospital care.

As approved by HCFA, the Waiver allowed the Division to expand Medicaid eligibility to most people with incomes at or below 133% FPL, and to expand assistance through subsidies to all working people (with insurance available from their employer) with incomes at or below 200% FPL.

This phase of reform cleanly broke the link between cash assistance and medical assistance by making receipt of cash assistance only one of several qualifying criteria. Eligibility streamlining, particularly the elimination of the asset test and the automation of the eligibility determination process, formed the foundation for DMA's new business approach to help eligible individuals obtain cost-effective health care coverage.

This expansion was authorized by the state legislature in July 1996 in Chapter 203 of the Acts of 1996, "An Act Providing for Improved Access to Health Care." Most of the terms of the Waiver were authorized; however, implementation of the IRP was not. Instead, Chapter 203 authorized the creation of a Commission to study the issue. Still, by March of 1998, over 100,000 new MassHealth members had been enrolled into the section 1115 waiver programs.

In 1997, further authorization was granted under Chapter 47 of the Acts of 1997, "An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth." This authorized the implementation of the IRP, with a restriction of the program to small businesses (50 or fewer employees) and their employees.

Prior to the Division's implementation of the IRP (originally scheduled for 1998), the federal government enacted Title XXI of the Social Security Act, allowing states to expand coverage to uninsured low-income children. The federal government also gave each state the option of extending coverage through expansion of its existing Medicaid program.

In November 1997, the legislature enacted Chapter 170 of the Acts of 1997, enabling the state to take advantage of the new federal revenue under Title XXI to cover uninsured children with family incomes

at or below 200% FPL. Title XXI imposed certain restrictions on states. For example, states can receive federal reimbursement only for children who are uninsured. Title XXI also effectively prohibits cost sharing for children with family income at or below 150% FPL.

To avoid gross inequities among children and to preserve the intent of the IRP, the Division expanded coverage to children below 200% FPL though a combination of approaches using authority granted under Title XXI and the authority already granted the Division under the 1115 Waiver to Title XIX. The resulting expansion includes the following:

- Expanded MassHealth coverage to children from 133% FPL (under the 1115 waiver) to 150% FPL (to be consistent with cost-sharing limits imposed by Title XXI)
- A new program called MassHealth Family Assistance, which covers children, their parents, and adults without children under Title XXI or Title XIX, depending on circumstances.
- Children who are uninsured and have no access to health insurance through a parent's employer receive direct coverage from the state by enrolling in a MassHealth managed care plan
- Families of children who are uninsured and have access to health insurance through a parent's employer are required to enroll in that insurance, and MassHealth Family Assistance subsidizes the premiums. (If the parent works for an eligible small business, these families would be eligible under the IRP).
- Families and their children who are insured through a parent's employment receive a premium subsidy through MassHealth Family Assistance. (Effectively, this is the employee subsidy portion of the IRP as approved by the federal government; that is, assistance is not limited to employees of small businesses as is the case for adults without children.)
- Adults without children who work for small businesses and have employer-provided health insurance receive a premium subsidy under MassHealth Family Assistance (Effectively, this is the employee-subsidy portion of the IRP as authorized by the state legislature.)

The components of this expansion that affect children – the increase in income limits for MassHealth up to 150% FPL and the implementation of MassHealth Family Assistance for children and their families – occurred in August 1998.

The Division implemented in two phases the remaining components of the original Insurance Reimbursement Program – MassHealth Family Assistance for adults without children who work for small businesses and the employer subsidy (now called the Insurance Partnership). The first component, limited to businesses that purchase insurance through a billing and enrollment intermediary, began on February 1, 1999. The second, expanding to all small businesses, began in January, 2000.

Insurance Market Reforms

In addition to expansion of state Medicaid programs, states began to address perceived market failure in the private health insurance market, specifically in the small group and non-group markets. Massachusetts passed small-group market reform in 1991 and non-group reform in 1996, implementing many of the laws that were included as part of the Health Insurance Portability and Accountability Act (HIPAA), enacted by Congress in 1996. Although Massachusetts' statute provides broader protections to the insured public, the passage of HIPAA ensures that ERISA plans are held to the same federal standards as non-ERISA plans. These reforms may succeed in establishing universal access to health insurance, but they do little to address affordability.

Small Group Market

Prior to 1991, small group health insurance was medically underwritten and there were few carriers who would offer coverage to all small groups. Those carriers that did offer small group coverage would impose coverage waiting periods and/or pre-existing condition limitations/exclusions or would charge high rates based upon the group's actual or potential health care utilization. Rates were likely to fluctuate widely from one year to the next and insurers would raise rates or drop small group coverage if a group had high medical expenses in the prior year. Massachusetts Blue Cross/Blue Shield served as the assigned risk pool, being unable to refuse customers.

Chapter 495 of the Acts of 1991 created M.G.L. c. 176J to regulate the small group health insurance market affecting groups with fewer than 25 eligible employees (including self-employed individuals). Carriers who elected to remain in Massachusetts' small group health insurance market were required to offer products, on an equal basis, to all small groups without medical underwriting. Products could have a six-month pre-existing condition limitation, but companies had to give credit toward the pre-existing condition limitation for every month of immediately previous small group coverage. According to the Division of Insurance's files, 38 companies elected to write small group business according to the provisions of M.G.L. c. 176J.

The law also prohibits small group carriers from charging rates that vary directly based upon any group medical condition or illness but permits these carriers to vary premiums within legislatively restricted rating bands based upon a group's members' ages, gender, industry, size (number of employees), participation rate (percentage of employees who elect coverage) and number of group employees whose risk is shared with the small group reinsurance pool. According to the statute's 3-year implementation period, companies were required to restrict the variance between the highest and the lowest rates charged to eligible groups in the same geographic area from a 4:1 rate band in 1992 (the highest rate could be no more than four times the lowest rate charged) to a 2:1 rate band in 1995.

The law replaced Massachusetts' Blue Cross/Blue Shield "assigned risk" function by requiring all carriers to accept all eligible small groups and by establishing a reinsurance pool. While all carriers must sell coverage, individual employees/dependents may be ceded to a reinsurance pool, operated by the insurers in the small employer group market, thereby helping spread the risk among all those using commercial insurers. Health Maintenance Organizations and Blue Cross/Blue Shield are not required to and do not participate in this reinsurance mechanism. The 1991 law also allowed for "association" programs– *e.g.*, the American Psychological Association - to exempt from the small group law. These programs had occasionally been used to assist groups to obtain coverage not subject to the small group law.

Chapter 297 of the Acts of 1996 amended M.G.L. c. 176J to extend the protections of the small group health insurance law to groups with between 26 and 50 eligible employees, to eliminate exemptions formerly allowed to carriers who were offering products to members of group associations and to eliminate gender as an allowable rate characteristic. According to the Division of Insurance files, 51 companies were writing small group business in 1996 according to the provisions of M.G.L. c. 176J; this includes insurers newly subject to the small group law because they were covering groups with 26-50 eligible employees or association groups previously exempt from the law.

The statutory change allowed carriers to implement a 3-year rate transition period for groups with between 26 and 50 employees who were newly subject to the statute, allowing their rates to compress from a 4:1 rate band beginning December 1, 1996 to a 2:1 rate band by December 1, 1998. All other

small groups were rated according to a 2:1 rate band immediately. As of August 1999, there were 34 carriers participating in the small group market following the departure of several smaller carriers from the market and the consolidation of other companies under one carrier.

Nongroup (Individual) Market

Prior to 1996, nongroup health insurance was medically underwritten and there were very few carriers who offered coverage in the market. Blue Cross and Blue Shield of Massachusetts, Inc. did offer a "plan of last resort", which is another way of saying an assigned risk pool, but it had both a waiting period before coverage would begin and a 3-year pre-existing condition limitation. All other companies only offered coverage to those persons meeting their medical underwriting standards and only offered policies with limited coverage, waiting periods, pre-existing condition limitations/exclusions and/or high rates based upon an individual's actual or potential health costs. Blue Cross and Blue Shield's rates were subject to an annual rate hearing at the Division of Insurance; other companies would change rates periodically based upon the experience of all persons holding a particular plan.

Chapter 297 of the Acts of 1996 created M.G.L. c. 176M to regulate the nongroup health insurance market. Under this law, carriers who elect to offer coverage to eligible Massachusetts residents who are not eligible for or covered under employment-based or government health plans are required to offer standardized nongroup products ("guaranteed issue" products) on an equal basis to all eligible individuals when initially eligible – usually because they lost health coverage within the past 63 days – or during annual open enrollment periods. These standardized products, as designed by the Nongroup Health Insurance Advisory Board, may not have any pre-existing condition limitations or waiting periods and must include a comprehensive array of benefits including preventive health care and unlimited prescription drug coverage. Rather than offer the standard benefit plan beginning October 1, 1997, many companies that offered medically underwritten plans elected to close their existing plans to new enrollments. As of October 1, 1997, 19 companies offered guaranteed issue nongroup policies in Massachusetts. Under the nongroup reform law, carriers that participate in the small group market are required to offer the guaranteed issue nongroup product. Currently, there are 34 carriers participating in the small group and nongroup market.

The nongroup statute prohibits nongroup carriers from charging rates that vary directly based upon any individual's medical condition or illness but permits these carriers to vary premiums within rating bands based upon an individual's age. According to the statute, carriers must restrict the variance between the highest and the lowest rates charged to eligible individuals in the same geographic area to a 2:1 rate band (the highest rate could be no more than two times the lowest rate charged) for rates offered as of October 1, 1997 with effective date of January 1, 1998.

Recent Developments

As least two developments over the last several months illustrate continued commitment in Massachusetts to the goal of expanding access to health insurance. In June, the Governor, Speaker of the House, and the Senate President convened a Task Force composed of more than 40 leaders from providers, employers, labor unions, consumer groups, and state government, to a conduct comprehensive assessment of the state of health care in Massachusetts, including access to insurance. In July, supporters of a ballot initiative calling for universal health insurance completed the process for assuring the initiative a place on the November 2000 state ballot. This State Planning Grant would provide support for the Task Force and for the ballot initiative, in the event it passes.

REQUEST FOR PREFERENCES

Building on the momentum of a strong economy, Massachusetts has made impressive strides toward covering the uninsured through an array of strategies involving private sector reforms and public sector program expansions. The impact of these initiatives has been a drop in the state's uninsurance rate for all ages from 12.6% in 1997 to 10.3% in 1998 (CPS). In comparison, the United States' uninsured rate climbed during this same time period from 16.1% to 16.3%. In fact, Massachusetts is one of just a few states that actually saw its rates of uninsurance decline during this period, with preliminary results from a state-sponsored, household survey actually reporting a 5.8% overall uninsurance rate for all ages.

With the State Planning Grant, Massachusetts will build upon its historical commitment to providing affordable health care to every resident by broadening its knowledge base of the remaining uninsured and creating flexible programs to meet their health care needs. The State Planning Grant would enable Massachusetts to build upon and consolidate these impressive gains in providing affordable insurance coverage. The formidable task of reducing the insurance rate to zero remains. This remaining 5.8% may be among the hardest to reach, presenting an even greater challenge for state policy makers. It is precisely this challenge that the State Planning Grant would allow Massachusetts to embrace.

Based on this record, we request that this application be granted preference.

STATEMENT OF PROJECT GOALS

The goals of the project are as follows:

1. Define "affordable" for residents based on income and family status.
2. Determine the most appropriate level of insurance coverage (benefits and deductibles) to serve as a "benchmark" based the most prevalent insurance products in various categories of subscribers.
3. Identify existing barriers to that benchmark level of insurance coverage (e.g. affordability; awareness; risk-taking behavior; competing priorities).
4. Develop proposals for achieving universal access to affordable insurance that support and enhance the private insurance market while ensuring that the safety net of public programs is available for those who need it.

The overarching goal of the State Planning Grant Program is to "provide access to health insurance coverage to all citizens by providing them with a number of data collection and planning strategies, along with viable insurance options to consider." The results of the project proposed in this application will support this Program goal in the following ways:

The challenge of developing options for achieving universal access is more complicated than developing options to expand coverage to low-income or otherwise disadvantaged populations. This project will result in information that Massachusetts and other states can use to address four questions that will be critical to the success of universal coverage options.

1. Affordability: In most cases where cost-sharing is required for low-income beneficiaries, there are strict limits that relate not to premium costs or the cost of services provided, but to income and family size. Who should determine what is "affordable" for people at higher incomes, and on what basis would that determination be made?

2. Comprehensiveness: Low-income residents need comprehensive insurance with first-dollar coverage because they cannot afford any significant out-of-pocket expenses. However there are tradeoffs when talking about people who could purchase in the private market: Not only do added benefits increase premium costs for everyone, but higher income people are able, and in many cases eager, to trade lower premiums for fewer covered services or higher deductibles. Who should determine what is a minimum standard benefit level, and on what basis would that determination be made?

3. Barriers to Access: For very low income populations, the primary barrier to health insurance or health care is cost. This is a relatively simple barrier with a relatively simple solution. However, as income increases, other barriers become evident. Among these are a lack awareness of existing options, a willingness to assume risk, and competing priorities. How can these barriers be identified and addressed?

4. Relationship between Public and Private: Until very recently, very few people who were enrolled in a public health insurance program had, or had access, to private health insurance. However, most people who have insurance obtain it directly or indirectly in the private market. How can this basic infrastructure be preserved and enhanced while ensuring that those who are still excluded from it are able to obtain appropriate coverage?

PROJECT DESCRIPTION

Project Narrative

DMA and its collaborating agencies have for the last several years been collecting and analyzing data related to the uninsured in Massachusetts and the impact of MassHealth and other programs on the uninsured. However, there are still several issues that require investigation. Issues that require quantitative data collection include the availability and prevalence of various insurance products and the cost and adequacy of these products. There also needs to be a qualitative analysis of stakeholders' attitudes toward existing products and programs, and potential coverage options.

The activities proposed in this application are designed to be collaborative, initially with the Core Project Team comprised of the Division of Medical Assistance (DMA), the Division of Health Care Finance and Policy (DHCFP), the Division of Insurance (DOI), and the Department of Public Health (DPH). Specific activities will require the involvement of the Executive Office of Elder Affairs (EOEA), the Department of Mental Health (DMH), the Department of Employment and Training (DET), the Department of Revenue (DOR), the Group Insurance Commission (GIC), and the University of Massachusetts.

The process of developing options and recommendations will include the Core Project Team as well as representatives of the Massachusetts State Senate and House of Representatives and representatives of the private sector, including Health Care For All, Associated Industries of Massachusetts, the Massachusetts Medical Society, the Massachusetts Hospital Association, League of Community Health Centers, Massachusetts Association of Chamber of Commerce Executives, and representatives of Massachusetts insurance companies.

Task 1: Establish data collection priorities to support collaborative, interagency planning process promoting access to non-episodic insurance coverage for all State residents. (October 1, 2000 – November 1, 2000)

Participating Agencies: DMA (Lead), DHCFP, DOI, DPH, EOEA

> Action Step 1: Define data needs for the development of proposals; catalog existing data sources; achieve consensus on data needs
>
> Action Step 2: Prioritize existing administrative, epidemiological and clinical data sources, as well as gaps in the existing data sources
>
> Action Step 3: Establish workplan for data collection and analysis

These activities will result in a comprehensive listing of data needs, existing and potential data sources, and gaps. This, combined with the workplan for the necessary data collection and analyses, will be disseminated to all participating agencies for review and project planning.

Task 2: Enter into a contract with one or more qualified vendor/consultant(s) for data collection, analysis, and technical assistance. This contract will augment existing capacity within the participating agencies. (November 1, 2000 – January 31, 2001)

Participating Agencies: DMA (Lead), DHCFP, DOI, DPH

Action Step 1: Based on the results of Task 1, draft a Scope of Services with associated timetables.

Action Step 2: Identify vendor(s) and obtain and evaluate bids (if applicable).

This Task will result in a contract with a vendor/consultant who can produce specified data products to support the project's analytic, planning and evaluation needs.

Task 3: Analyze and synthesize data from research sources, including survey data and market data. (January 31, 2001 – April 30, 2001)

Participating Agencies: DHCFP (Lead), DMA, DOI, DPH, EOEA, DMH, DET, DOR, GIC

Action Step 1: Conduct literature review on consumers' preferences regarding insurance, benefit packages, and willingness to pay.

Action Step 2: Conduct meta-analysis of existing data sources to determine risk factors/predictors of uninsurance, including consumer demographics and consumer preference issues. Descriptive population data drawn from the CPS, NASF, DHCFP, MEPS and Department of Employment and Training (DET) data sets;

Action Step 3: Define and analyze key characteristics of local insurance markets and service utilization patterns of the uninsured and underinsured populations.

Sources will include:

- Demographic and utilization data from Uncompensated Care Pool Eligibility (Analysis)
- Screening and Intake Process and hospital claim submissions (Analysis)
- Hospital and health center accounting system data identifying self-pay patients and their health care expenditures (Development of data collection methodology and analysis)
- Division of Insurance information on costs of existing insurance products within the group and individual markets. Descriptions will include benefit limits, co-payments and deductibles (Analysis)
- Standard quarterly reports filed by employers with the Department of Employment and Training to assess prevalence of various insurance products (and related costs) in the small and large group markets (Modification of existing forms)
- Demographic data on consumers stratified by insurance product (i.e. description of population purchasing nongroup insurance products, etc.) (Analysis)
- Survey of current nongroup product subscribers to assess adequacy of benefits (Survey design, administration and analysis)
- Focus group data. (Analysis)

We expect these activities to result in a comprehensive picture of the insurance market in Massachusetts, the state's uninsured population, and the barriers to affordable insurance coverage that many of the uninsured face. Specifically, we expect to determine:

- What is a reasonable definition of "affordable" by determining what people at various income levels are currently paying or would be willing to pay, both in premiums, cost-sharing and payments for non-covered services.
- How adequate are the existing insurance products for people at various income levels (for example, by identifying the percentage of self-pay expenditures that result from uninsurance vs. non-covered services).
- The amount of variation in benefits (covered services, limitations, premiums, co-payments, co-insurance and deductibles) among nongroup, small group, large group, and self-insured plans.
- The extent to which cost is a barrier for people whose income would not qualify them for assistance under MassHealth .
- The potential impact that changes in benefits or cost sharing formulas would have on the market (including on the majority of residents who are insured).

TASK 4: Develop feasible strategies to surmount existing barriers to coverage and guarantee access to affordable insurance coverage for all Massachusetts residents. (April 15, 2001-July 31, 2001)

Participating Agencies: DMA (Lead), EOHHS, DHCFP, DOI, DPH, EOEA, DMH

Action Step 1: Using the information resulting from the above tasks and action steps, develop a comprehensive plan detailing strategies to provide coverage to all State residents. (April 30, 2001 – May 15, 2001)

Action Step 2: Conduct focus groups with key stakeholders to assess their reactions to various approaches to expanding insurance access. Groups will include: union representatives; employers (small and large); chambers of commerce; consumers of nongroup insurance products, potential subscribers/enrollees (targeting those who are, or are likely to become, uninsured). (April 15, 2001 [planning and recruitment] - May 31, 2001)

Action Step 3: Develop position paper on strategies for ensuring access to affordable coverage, and disseminate plan to consultants for review and commentary. Consultants will include key informants from leading academic and research institutions, representatives of consumer advocacy groups, and representatives of the private and public sectors. (May 31, 2001 – June 30, 2001)

Action Step 4: Convene core work group of consultants/ key informants to establish consensus on recommended strategies. (June 30, 2001 – July 31, 2001)

We expect that this Task will result in the development of a set of recommended coverage options about which consensus among key collaborators will be reached. Based on this, we will write a report that outlines these options, and distribute the report to participating agencies and the Steering Committee.

TASK 5: Create a strategic plan for funding and implementation of model to ensure that proposed coverage overage options are administratively feasible, politically viable, and cost-effective for the Commonwealth, its taxpayers, employers, and potential beneficiaries. (August 1, 2001 – September 7, 2001)

Participating Agencies: DMA (Lead), EOHHS, DHCFP, DOI, DPH, EOEA, DMH, GIC, Representatives of the Massachusetts State Senate and House of Representatives

Action Step 1: Using existing data on benefits, costs, caseload, and potential enrollment from participating agencies, as well as relevant information resulting from Task 3, assign cost-estimates to each of the potential coverage options. Such estimates will be based on a dynamic, not static, analysis of the options, and will reflect the potential impact on the existing insurance market and the currently insured. (August 1, 2001 – August 22, 2001)

Action Step 2: Determine potential funding sources for each coverage option (August 7, 2001 – August 22, 2001)

Action Step 3: Identify the state or federal statutory or regulatory changes that would be required in order to implement each of the coverage options. (August 7 – August 22, 2001)

Action Step 4: Prepare a detailed report reflecting the information resulting from Action Steps 1-3, and disseminate to Interagency Working Group for review and comment. (August 22 – September 7, 2001)

We expect that this Task will result in a detailed report outlining the potential coverage options that would result in universal access to affordable insurance. This report will include recommendations regarding the definition of affordability, an appropriate minimum benefit level, a description of barriers faced by the uninsured, and how the proposed coverage options address these barriers.

TASK 6: Write a report to the Secretary of Health and Human Services that conforms to the guidelines to be issued by federal Program staff. (September 7, 2001* – September 30, 2001)

Participating Agencies: DMA (Lead), EOHHS, DHCFP, DOI, DPH, EOEA

Action Step 1: Revise proposed coverage options based on Interagency Working Group input.

Action Step 2: Draft report based on Program guidelines

Action Step 3: Distribute draft report to Steering Committee for review and approval

Action Step 4: Revise report based on Steering Committee input

The Team expects that at the conclusion of this project we will have developed a set of coverage options that are feasible and affordable for subscribers, employers, providers, insurance companies, and the taxpayers. The Team will consider and evaluate any reasonable approaches and combinations of approaches to achieving this goal, including, but not limited to, the following:

1. Closing existing gaps in MassHealth eligibility for those who have very low income but who do not meet certain categorical requirements.
2. Expanding eligibility for existing public programs.
3. Ensuring the availability of affordable insurance products.
4. Providing some form of financial assistance for those below a defined income level who purchase a group or individual insurance product.
5. Expanding current subsidy programs for residents with employer-based insurance.

We expect that this Task will result in a report being submitted to the Secretary of the Department of Health and Human Services by September 30, 2001. This report will detail proposed options for achieving universal access to affordable health insurance and will be presented in a manner that conforms to Program guidelines.

* This reflects the final stages of the drafting of this report. We expect to draft sections of the report as Tasks are completed.

Project Matrix

<table>
<tr><td colspan="4">TASK 1: Establish data collection priorities to support collaborative, interagency planning process promoting access to non-episodic insurance coverage for all State residents.</td></tr>
<tr><td colspan="4">▪ Action Step 1: Define data needs for the development of proposals; catalog existing data sources; achieve consensus on data needs.
▪ Action Step 2: Prioritize existing administrative, epidemiological and clinical data sources, and gaps in the existing data sources.
▪ Action Step 3: Establish workplan for data collection and analysis.</td></tr>
<tr><td>Participants
DMA (Lead)
DHCFP, DOI, DPH, EOEA</td><td>Timetable:
10/1/00 – 11/1/00</td><td>Anticipated Results
Comprehensive listing of data needs, existing and potential data sources, and gaps; detailed workplan for data collection and analyses.</td><td>Evaluation/Measure:
Participating agencies approve workplan.</td></tr>
<tr><td colspan="4">TASK 2: Enter into a contract with one or more qualified vendor/consultant for data collection and analysis, and technical assistance. This contract will augment existing capacity within the participating agencies.</td></tr>
<tr><td colspan="4">▪ Action Step 1: Based on the results of Task 1, draft a Scope of Services with associated timetables.
▪ Action Step 2: Identify vendor(s) and obtain and evaluate bids (if applicable).</td></tr>
<tr><td>Participants

DMA (Lead)
DHCFP, DOI, DPH,</td><td>Timetable:
11/1/00-1/31/01</td><td>Anticipated Results: A contract with a vendor/consultant who can produce specified data products to support the project's analytic, planning and evaluation needs.</td><td>Evaluation/Measures:
▪ Signed vendor contract on file at DMA.

▪ Work plan and time line for specified data products on file at DMA.

▪ Specified data products delivered to contracting agency within a timely manner.</td></tr>
<tr><td colspan="4">TASK 3: Analyze and synthesize data from existing sources, including survey data and market data.</td></tr>
<tr><td colspan="4">▪ Action Step 1: Conduct literature review on consumers' preferences regarding insurance, benefit packages, and willingness to pay.
▪ Action Step 2: Conduct meta-analysis of existing data sources to determine risk factors/predictors of uninsurance, including consumer demographics and consumer preference issues. Descriptive population data drawn from the CPS, NASF, DHCFP, MEPS and Department of Employment and Training (DET) data sets.2
▪ Action Step 3: Define and analyze key characteristics of local insurance markets and service utilization patterns of the uninsured and underinsured populations. (See Project Narrative for details.)</td></tr>
</table>

<table>
<tr><td colspan="4">TASK 3, continued</td></tr>
<tr><td>Participants:
DHCFP (Lead), DHCFP, DOI, DPH, EOEA, DMH, DET, DOR, GIC</td><td>Timetable:
<u>1/31/00-4/30/01</u></td><td>Anticipated Results: A comprehensive picture of the insurance market in Massachusetts, the state's uninsured population, and the barriers to affordable insurance coverage that many of the uninsured face. See Project Narrative for detail.</td><td>Evaluation/Measurement:
Creation of report providing a detailed description of the state's uninsured population and an in-depth analysis of the barriers to affordable insurance coverage faced by this diverse group, and factors predisposing Massachusetts residents to loss of coverage or underinsurance.</td></tr>
<tr><td colspan="4">TASK 4: Develop feasible strategies to surmount existing barriers to coverage and guarantee access to affordable insurance coverage for all Massachusetts residents</td></tr>
<tr><td colspan="4">▪ <u>Action Step 1:</u> Using the information resulting from the above tasks and action steps, develop a comprehensive plan detailing strategies to provide coverage to all State residents.
▪ <u>Action Step 2:</u> Conduct focus groups with key stakeholders to assess their reactions to various approaches to expanding insurance access. Groups will include: union representatives; employers (small and large); chambers of commerce; consumers of non-group insurance products, potential subscribers/enrollees (targeting those who are, or are likely to become, uninsured).
▪ <u>Action Step 3:</u> Develop position paper on strategies for ensuring access to affordable coverage, and disseminate plan to consultants for review and commentary. Consultants will include key informants from leading academic and research institutions, representatives of consumer advocacy groups, and representatives of the private and public sectors.
▪ <u>Action Step 4:</u> Convene core work group of consultants/ key informants to establish consensus on recommended strategies.</td></tr>
<tr><td>Participants:
DMA (Lead), EOHHS, DHCFP, DOI, DPH, EOEA, DMH</td><td>Timetable:
4/15/2001 – 7/31/2001</td><td>Anticipated Results:
Consensus on coverage options will be reached among Core Project Team and key collaborators; report outlining options is prepared for Steering Committee.</td><td>Evaluation/Measures:
Steering Committee reviews and approves outline of recommendations.</td></tr>
</table>

<table>
<tr><td colspan="4">TASK 5: Create a strategic plan for funding and implementation of model to ensure that proposed coverage overage options are administratively feasible, politically viable, and cost-effective for the Commonwealth, its taxpayers, employers, and potential beneficiaries.</td></tr>
<tr><td colspan="4">▪ Action Step 1: Using existing data on benefits, costs, caseload, potential enrollment from participating agencies, as well as relevant information resulting from Task 3, assign cost-estimates to each of the potential coverage options. Such estimates will be based on a dynamic, not static, analysis of the options, and will reflect the potential impact on the existing insurance market and the currently insured. (August 1, 2001 – August 22, 2001)
▪ Action Step 2: Determine potential funding sources for each coverage option. (August 7, 2001 – August 22, 2001)
▪ Action Step 3: Identify the state or federal statutory or regulatory changes that would be required in order to implement each of the coverage options. (August 7 – August 22, 2001)
▪ Action Step 4: Prepare a detailed report reflecting the information resulting from Action Steps 1-3, and disseminate to Interagency Working Group for review and comment. (August 22 – September 7, 2001)</td></tr>
<tr><td>Participants:
DMA (Lead), EOHHS, DHCFP, DOI, DPH, EOEA, DMH,GIC, state legislative representation</td><td>Timetable:
8/1/2001 – 9/7/2001</td><td>Anticipated Results:
A detailed report outlining the potential coverage options that would result in universal access to affordable insurance.</td><td>Evaluation/Measures:
▪ One or more of the coverage options are determined by stakeholder group to be feasible.
▪ Recommended coverage option(s) address key issues of affordability, benefit level, barriers, and public/private balance.</td></tr>
<tr><td colspan="4">TASK 6: Write a report to the Secretary of Health and Human Services that conforms to the guidelines to be issued by federal Program staff. (September 7, 2001* – September 30, 2001)</td></tr>
<tr><td colspan="4">▪ Action Step 1: Revise proposed coverage options based on Stakeholder input.
▪ Action Step 2: Draft report based on Program guidelines.
▪ Action Step 3: Distribute draft report to Steering Committee for review and approval.
▪ Action Step 4: Revise report based on Steering Committee input.</td></tr>
<tr><td>Participants: DMA (Lead), DHCFP, DOI, DPH, EOEA</td><td>Timetable:
9/7/01 –9/30/01</td><td>Anticipated Results:
A report being submitted to the Secretary of the Department of Health and Human Services. See Project Narrative for detail.</td><td>Evaluation/Measures:
Submission to the Secretary of Health and Human Services of a report that conforms to the guidelines to be issued by federal Program staff.</td></tr>
</table>

* This reflects the final stages of the drafting of this report. We expect to draft sections of the report as Tasks are completed.

Governance

Governance Structure

Lead Organization: Division of Medical Assistance (DMA)

Core Project Team (Team): Comprised of representatives of four key state agencies: DMA, the Division of Health Care Finance and Policy (DHCFP), the Division of Insurance (DOI), and the Department of Public Health (DPH). The Team performs will perform all of the day to day work of the project.

Steering Committee: Comprised of commissioner level representatives of the executive branch agencies that have been involved in the state's health reform activities – DMA, DHCFP, DOI, DPH – or that that contribute to state health policy at the cabinet level – the Executive Office of Administration and Finance (A&F), the Office of Consumer Affairs (OCA), the Executive Office of Health and Human Services (EOHHS), the Executive Office of Elder Affairs (EOEA), and the Department of Mental Health (DMH). Legislative branch representatives from the Joint Committees on Health Care, Insurance and Human Services will provide input to the steering committee on the project. Members and staff of these committees will be kept closely apprised of progress and results and will be able to pose questions that are of special interest to the Legislature.

The Steering Committee is the primary decision-making body for this project.

Interagency Working Group: Comprised of steering committee members, key legislative representatives, other government agencies, and representatives of private organizations with a role or stake in the Commonwealth's plan to provide access to health insurance for all citizens. The following private Massachusetts organizations--representing purchasers, payers, providers, and consumers will be invited to participate in the interagency working group:

- Health Care For All
- Massachusetts Business Association
- Massachusetts Association of HMOs
- Massachusetts Medical Society
- Massachusetts Hospital Association
- Massachusetts Healthcare Purchaser Group
- Massachusetts League of Community Health Centers
- Associated Industries of Massachusetts
- Boston HealthNet
- Cambridge Network Health

Members from most of the above organizations are also members of the Massachusetts Health Care Task Force convened by the Governor, Speaker of the House and the Senate President and are charged with looking at the costs, access to and quality of health care in Massachusetts.

The Interagency Working Group will be advisory in nature, and will provide advice, input, feedback , and access to information.

Coordination and Management of Project

The Division of Medical Assistance, as the lead agency, is responsible for coordinating the day-to-day work of the project and the Core Project Team, maintaining contact with the national program office, and for bringing important decisions to the Steering Committee for discussion at the monthly meetings. DMA is also responsible for managing any contracts with vendors or consultants that will be required for this project. The Project Director is a full time manager at the Division of Medical Assistance.

The work on this project will be coordinated through weekly Core Project Team meetings facilitated by the Project Director and guided by written work plans. Each member of the Core Project Team will have a particular piece of the project as a main responsibility, but all staff will be asked to review and contribute to others' work. The Team will prepare materials for the monthly Steering Committee meetings and undertake follow-up tasks. The Steering Committee is the primary decision-making body, and will make decisions about the project by consensus.

The Core Project Team will also plan three Interagency Working Group meetings, create and update the project's website, and maintain close, informal contact with all members of the Interagency Working Group.

The Interagency Working Group will provide perspective, access to information, advice on approaches to test, and feedback on their progress. This group will meet formally three times during the project, in October, March and August. Members will be kept apprised of progress on the project through information posted regularly to the project's website and through informal contacts with project staff.

EVALUATION

A self-evaluation or "peer review" team will be commissioned to monitor the efficacious and efficient progress of the project. The team will include the Commissioners from the Division of Medical Assistance, the Department of Insurance, the Department of Public Health and the Division of Health Care Finance and Policy. The team will meet monthly to evaluate the short-term progress and reassess the long-term goals accordingly.

The Project Director will provide periodic updates of our progress to State Planning Grant Program staff, and will respond in a timely fashion to all questions, requests for clarification, or requests for more information.

The Core Project Team believes that to be useful to the Secretary of Health and Human Services and other states (Grantees and others), the framework for the final report should be developed through a collaborative effort. Because each of the Grantee states will bring to the project a different perspective, different approach, different experiences, and different strengths, each state would benefit by contributing to the development of the final report. Therefore, the Core Project Team would be happy to participate in meetings., conference calls, or other information exchanges with other Grantees and Planning Grant Program Staff to ensure that we all produce the best possible product.

Upon completing the project, the Division of Medical Assistance will submit a comprehensive report to the Secretary of Health and Human Services, abiding by the reporting guidelines established by the State Planning Grant staff. The report will serve as a model for other states to adopt or modify in their efforts to provide expanded coverage. It will detail the demographics of our uninsured population; describe our efforts in broadening insurance coverage, from initial strategy to budgeting to implementation; and describe our findings and analysis of the project's implementation progress.

Collectively, the team will identify relevant data sources and determine the necessary information to be gathered. The Division of Medical Assistance will contract with a research entity to perform reliably sound and externally valid survey design and data collection on a variety of populations, including insurance companies, hospitals, providers and subscribers. The peer review team will produce an individual report of findings for each of the seven analyses outlined in the project matrix. The reports will be submitted to the lead agency and distributed to the team members for review. Any discussion or further evaluation of analysis will occur at the peer-review level. Once the data from each survey has been collected and analyzed, the team will synthesize the findings from each activity and determine recommendations. These findings will be summarized as a report for submittal to the Department of Health and Human Services.